

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
10938											
1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 75 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 409 High street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First William Middle Davis Last Abbott			4. DATE OF DEATH Month Aug. Day 22 Year 1967			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 5, 1881			9. AGE (In years last birthday) 86 yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Hardware store employee				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Gray's Is., Dorchester Co., U.S.			
13. FATHER'S NAME Samuel J. Abbott						14. MOTHER'S MAIDEN NAME Cilistine Langrall					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-07-7925				17. INFORMANT Mrs. Eileen V. Abbott, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 2 days											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 8/20 , 19 67 , to 8/22 , 19 67 , that (I) (we) last saw the deceased alive on 8/22 , 19 67 , and that death occurred 8:30 M. from the causes and on the date stated above.											
22a. SIGNATURE Alfred R. Maryanov M.D.						22b. DATE SIGNED 8/23/67					
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV						22d. ADDRESS 610 RACE ST, CAMBRIDGE MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF Aug. 24, 1967				23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery, Cambridge, Md.			
23d. LOCATION (City, town or county) (State)				23e. REC'D BY REGISTRAR Charles Judge				23f. REGISTRAR'S SIGNATURE Charles Judge			
23g. FUNERAL DIRECTOR Theresa A. Thomas				23h. ADDRESS Cambridge, Md.				23i. DATE AUG 25 1967			

Received of the Treasurer of the County of ...

the sum of ... Dollars ...

for ...

...

...

...

...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove both papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10940

CERTIFICATE OF DEATH

10940

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>3 days, 17 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville, Md.</u> <u>21638</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>Byard</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>19 67</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-1870</u>		9. AGE (In years last birthday) <u>96</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gen. Carpenter Contractor/Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Baker</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-12-1476</u>		17. INFORMANT Address <u>Hospital admission Record.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>355X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CEREBRAL VASCULAR INSUFFICIENCY</u> DUE TO (c) <u>CACHEXIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>2 DAYS</u> <u>3+ YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC PANCREATITIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUG 11</u> , 19 <u>67</u> , to <u>AUG 12</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>AUG 12</u> 19 <u>67</u> , and that death occurred at <u>6:45</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Sean M. Killoran</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 12, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>SEAN M. KILLORAN</u>		22d. ADDRESS <u>7415 BLAIR RD. WASHINGTON DC.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>August 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grasonville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Grasonville, Q.A. Co. Md.</u>	
24. FUNERAL DIRECTOR <u>James B. Baitor</u> <u>Baitor Bros.</u> <u>W.F. M.</u>		ADDRESS <u>Centerville Md</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 15 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

114-2108

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne R.F.D. #3</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George W. Barnes</u>			4. DATE OF DEATH Month Day Year <u>August 15, 1967</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-16-16</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmert</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Helen Barnes; Route #3, Princess Anne</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> EXAMINER'S NAME (Type) <u>Alfred R. Maryanov</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>August 15, 1967</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/17</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beechwood Memorial</u>			
22d. LOCATION (City, town, or county) <u>Princess Anne, Somerset Co.</u>		22e. REC'D BY REGISTRAR <u>August 21 1967</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>James L. Linn</u>		ADDRESS <u>Princess Anne, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JULY 1, 1900

NEW YORK
JULY 1, 1900

NEW YORK
JULY 1, 1900

NEW YORK
JULY 1, 1900

NEW YORK
JULY 1, 1900

NEW YORK
JULY 1, 1900

NEW YORK
JULY 1, 1900

NEW YORK
JULY 1, 1900

NEW YORK
JULY 1, 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10942

CERTIFICATE OF DEATH

10942

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Caroline QUEEN ANNE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. LENGTH OF STAY IN 1b 35 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYDEL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL				d. STREET ADDRESS		052	
3. NAME OF DECEASED (Type or print) First Middle Last ESTELLE MAUDE BOSELY				4. DATE OF DEATH Month Day Year AUGUST 30 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-12-88		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN W BOSELY				14. MOTHER'S MAIDEN NAME MARTHA JANE SLAUGHTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address RECORDS OF THE EASTERN SHORE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 300.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) schizophrasia - Paranoid							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE Felipe Dominguez				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) FELIPE DOMINGUEZ M. D.		22d. ADDRESS EASTERN SHORE STATE HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-3-67		23c. NAME OF CEMETERY OR CREMATORY Templeville		23d. LOCATION (City or Town) (County) (State) Templeville, Md.	
24. FUNERAL DIRECTOR J.E. Boulois Greensboro, Md.				25a. REC'D BY REGISTRAR DATE SEP 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

RECEIVED
JAN 10 1964

1000

1000

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

1000

RECEIVED

RECEIVED

RECEIVED

RECEIVED

1000

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

10943

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10943

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Cambridge Md. Hospital		d. STREET ADDRESS 923 Phillips St. Ext.	
3. NAME OF DECEASED (Type or print) John Henson Bowley		4. DATE OF DEATH Month August Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1884
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Bowley		14. MOTHER'S MAIDEN NAME Harriet Spicer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-70-7842	
17. INFORMANT Agnes Pinder; Cambridge, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO (b) 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 8/21/67	
EXAMINER'S NAME (Type) John Mace Jr. MD.		22. DATE SIGNED Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/15/67	
23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Cambridge, Dor. Md.	
24. FUNERAL DIRECTOR StClair Funeral Directors		25. REC'D BY REGISTRAR AUG 22 1967	
ADDRESS Cambridge, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Young	

1964

1. The first part of the report is devoted to a general survey of the situation in the field of international law. It is followed by a detailed analysis of the various aspects of the problem, and finally by a series of conclusions and recommendations.

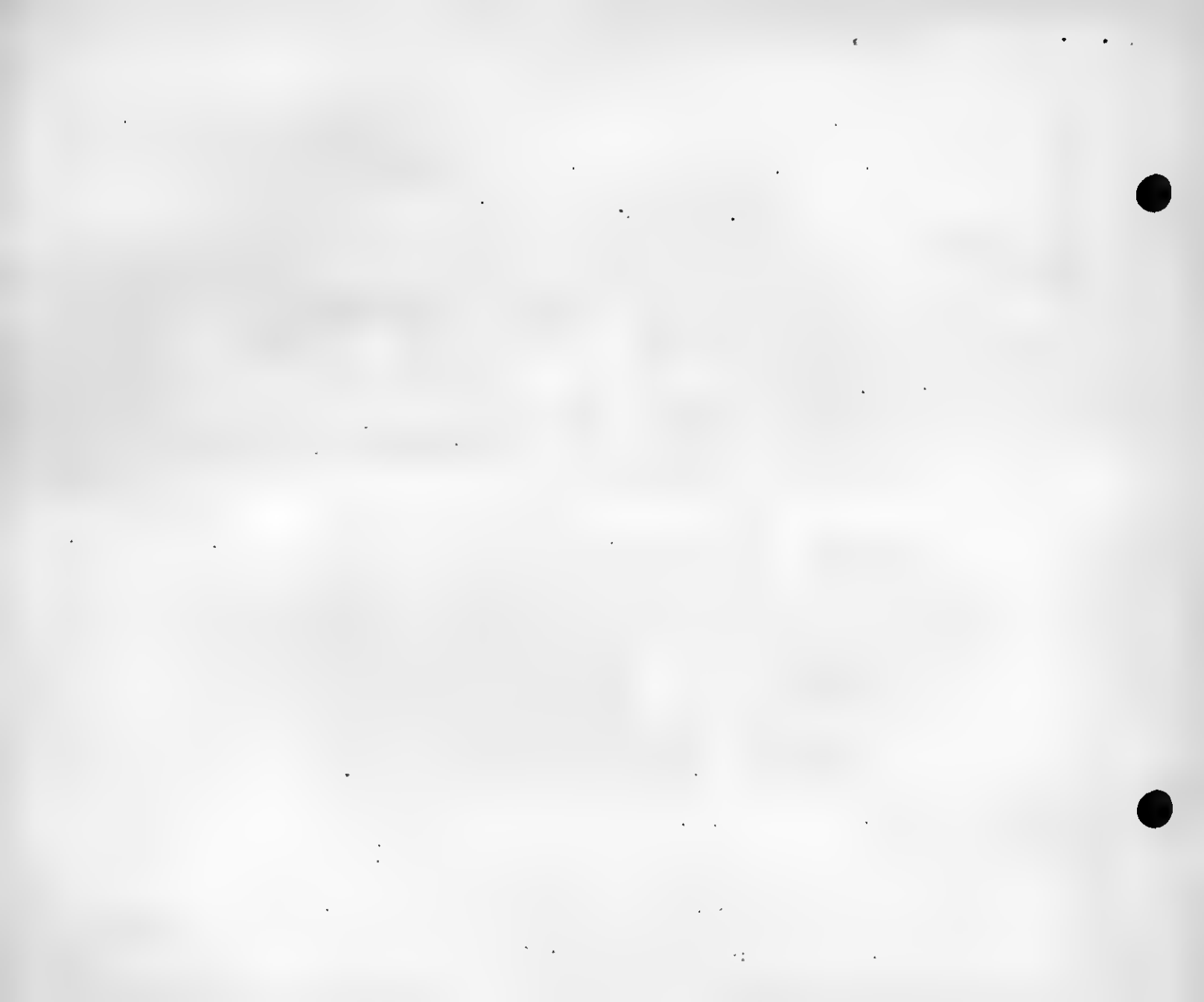
2. The second part of the report is devoted to a detailed analysis of the various aspects of the problem. It is followed by a series of conclusions and recommendations.

3. The third part of the report is devoted to a detailed analysis of the various aspects of the problem. It is followed by a series of conclusions and recommendations.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN ID <u>3 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glasgow Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u> d. STREET ADDRESS <u>Eden</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Ida</u> First <u>LEMON</u> Middle <u>Brittingham</u> Last			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1967</u>						
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 16, 1880</u>		9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u>10</u> Days <u>4</u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Crocherson, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Todd</u>					14. MOTHER'S MAIDEN NAME <u>Melvinia Bramble</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. James McNamara (Son)</u> <u>305 Annapolis St., Annapolis, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>HYPERTENSION</u>									INTERVAL BETWEEN ONSET AND DEATH <u>RECENT</u> <u>YEARS</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> this hospital attended the deceased from <u>8-20, 1967</u> , to <u>8-20, 1967</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>8-20, 1967</u> , and that death occurred at <u>7:25</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>James F. McCarter, M.D.</u>						22b. DATE SIGNED <u>8-20-67</u>		22c. PHYSICIAN'S NAME (Type) <u>JAMES F. MCCARTER, M.D.</u>	
22d. ADDRESS <u>Box 38C</u> <u>CAMBRIDGE, MARYLAND</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 23, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Fruitland, Maryland</u>			
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>						25a. REC'D BY REGISTRAR DATE <u>AUG 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10945

CERTIFICATE OF DEATH

10945

1. PLACE OF DEATH a. COUNTY DORCHESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY ICOMICO	
c. LENGTH OF STAY IN 1b 9 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 783 FITZWATER ST., SALISBURY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS 783 FITZWATER ST., SALISBURY	
3. NAME OF DECEASED (Type or print) SEAFIRE		4. DATE OF DEATH Month AUG. Day 4 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME NATHANIEL BROWN		14. MOTHER'S MAIDEN NAME ALICE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -		16. SOCIAL SECURITY NO. 217-10-3524A	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4014 IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Senile cachexia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypochromic anemia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 26, 1967 , to August 4, 1967 , that (I) (we) last saw the deceased alive on August 4, 1967 , and that death occurred at 8:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Carlos F. Barroso		22b. DATE SIGNED 8-4-67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO		22d. ADDRESS Hurlock Dorchester Co Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/9/67	23c. NAME OF CEMETERY OR CREMATORY Green Arches Cemetery	23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico md
24. FUNERAL DIRECTOR Clinton F Stewart		25a. REC'D BY REGISTRAR Salisbury Md	
25b. REGISTRAR'S SIGNATURE John J. Judge		DATE AUG 8 1967	

10946

CERTIFICATE OF DEATH

10946

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS R.F.D.	
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL IRVING CHANCE		4. DATE OF DEATH Month Day Year AUGUST 4 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/94
9. AGE (In years last birthday) yrs 72		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR PENTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Queen anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALTER NATHANIEL CHANCE		14. MOTHER'S MAIDEN NAME LILLIAN ELIZABETH ELLERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - no		16. SOCIAL SECURITY NO. 181-05-7793A	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis and hypertension DUE TO (c) 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 30 , 19 67 , to August 4 , 19 67 that (I) (we) last saw the deceased alive on August 4 , 19 67 , and that death occurred at 2:00 p.m. from causes and on the date stated above.			
22a. SIGNATURE Carlos F. Barroso		22b. DATE SIGNED 8/4/67	
22c. PHYSICIAN'S NAME (Type) CARLOS F. BARROSO		22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/6/67	23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.	23d. LOCATION (City or Town) (County) (State) Rock Hall, Md.
24. FUNERAL DIRECTOR J. Willis Wells		25a. REC'D BY REGISTRAR DATE AUG 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CS

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																	
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland b. COUNTY <u>Dorchester</u> </u>												
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>			c. LENGTH OF STAY IN 1b <u>4 yrs. 21 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg</u>												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Belle Haven Nursing Home</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>CELIA</u> Middle <u>MARTIN</u> Last <u>COULBOURNE</u>					4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1967</u>												
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 23, 1908</u>		9. AGE (In years last birthday) <u>59</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.																
Months	Days																
	Hours																
	Min.																
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Co., Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>William J. Hurlock</u>					14. MOTHER'S MAIDEN NAME <u>Mahalia Thomas</u>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Betty C. Williamson, Williamsburg, Md.</u>												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile cachexia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)										
21. I certify that (I) (this hospital) attended the deceased from <u>1-4-66</u>, 19<u>66</u>, to <u>8-21</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>August 21, 1967</u>, and that death occurred at <u>3:10 PM</u>, from the causes and on the date stated above.																	
22a. SIGNATURE <u>C. F. Barroso</u>								22b. DATE SIGNED <u>8-21-67</u>									
22c. PHYSICIAN'S NAME (Type) <u>CARLOS F BARROSO</u>					22d. ADDRESS <u>Hurlock Md</u>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Aug. 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Federalburg, Maryland</u>										
24. FUNERAL DIRECTOR <u>J. J. Frampton and son</u>					25a. REC'D BY REGISTRAR <u>AUG 30 1967</u>												
ADDRESS <u>Federalburg, Maryland</u>					25b. REGISTRAR'S SIGNATURE <u>Charles J. J. J.</u>												

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10948

10948

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cambridge</u>		c. LENGTH OF STAY IN 1b <u>5 yrs. 17 mos. 12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>Tilghman</u>	
3 NAME OF DECEASED (Type or print) First <u>Harriett P.</u> Middle <u>Covington</u> Last <u></u>		4 DATE OF DEATH Month <u>08</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>11-30-88</u>
9 AGE (In years last birthday) <u>78</u> yrs		10 IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY KINNAMON</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT DUNCAN</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		16 SOCIAL SECURITY NO <u>214-12-6014</u>	
17 INFORMANT <u>med. Records</u> Address <u>Eastern Shore State Hospital</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN DEATH AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>Chronic Brain Syndrome; Anemia; Pneumonia</u>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f (City or town) (County) (State)
21 I certify that (this hospital) attended the deceased from <u>7-2-</u> , 1962 to <u>8-19-</u> , 1967 that (I) <u>SSH</u> last saw the deceased alive on <u>8-19-</u> 1967 and that death occurred at <u>8:30 P</u> M, from causes and on the date stated above			
22a SIGNATURE <u>Edward Lewis Jr</u>		22b DATE SIGNED <u>8-19-67</u>	
22c PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS JR</u>		22d ADDRESS <u>ESSH, CAMBRIDGE, MD.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>8/22/1967</u>	<u>ST. JOHN'S</u>	<u>TILGHMAN, MD</u>
24. FUNERAL DIRECTOR <u>Marion E. Newland SM</u>		25a. REC'D BY REGISTRAR <u>AUG 23 1967</u>	
ADDRESS <u>Kastow, Md</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10549

10948

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE (RURAL)		c. LENGTH OF STAY IN 1b 2 YRS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL			d. STREET ADDRESS 927 JOHNSON STREET		
3. NAME OF DECEASED (Type or print) First Middle Last MARY PRISCILLA COX			4. DATE OF DEATH Month Day Year AUGUST 22 19 67		
5. SEX FEMALE	6. CO. OR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04-19-36	9. AGE (In years last birthday) 31 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red) WAITRESS		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND	
13. FATHER'S NAME WILLIAM AUSTIN		14. MOTHER'S MAIDEN NAME JANE GIVANS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO 218-16-8023		17. INFORMANT Mrs. Florence Hooper (Daughter)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) pneumonia DUE TO (b) Chronic brain syndrome DUE TO (c) smoking Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A			
20c. TIME OF INJURY Month, Day, Year Hour : m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 06-04-65 , 19 65 , to 08-22-67 , 19 67 , that (I) (we) last saw the deceased alive on 08-22 , 19 67 , and that death occurred at 8:20 P.M. causes and on the date stated above					
22a. SIGNATURE John Blair Webster		22b. DATE SIGNED August 22, 1967		22c. PHYSICIAN'S NAME (Type) JOHN BLAIR WEBSTER M.D.	
22d. ADDRESS EASTERN SHORE STATE HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 26, 1967		23c. NAME OF CEMETERY OR CREMATORY Allen Cemetery	
23d. LOCATION (City or Town) Allen, Maryland		(County)		(State)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR AUG 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

10950

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10950

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY N 1b 12 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 211 East Appleby Ave.				d. STREET ADDRESS 211 E. Appleby Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katie Hurley Dayton				4. DATE OF DEATH Month Aug. Day 16. Year 19 67			
5. SEX Female	6. CO. OR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/1882	9. AGE (In years last birthday) 85 yrs	IF UNDER 1 YEAR Months 85 Days 85	IF UNDER 24 HRS Hours 85 Min 85	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Levin H. Hurley				14. MOTHER'S MAIDEN NAME Elizabeth Beard			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Orville Dayton Address 211 E. Appleby Ave. Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Instant						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER'S NAME (Type) John Mace Jr. M.D.		22. DATE SIGNED 8/17/67		Address (Street city, town or county) Cambridge, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 8/19/67		23. NAME OF CEMETERY OR CREMATORY Elloitt Cemetery		23d. LOCATION (City or town) (County) (State) Dorchester Co., Md.	
24. FUNERAL DIRECTOR Willoughby Funeral Director. East New Market Md.				25. REC'D BY REGISTRAR AUG 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

10951

10951

Item#23 FilmG392 8/24/67 hr MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY IN 15 All life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 801 Fairmount Ave.		d. STREET ADDRESS 801 Fairmount Ave.	
3. NAME OF DECEASED (Type or print) Hansel Green		4. DATE OF DEATH Month August Day 4 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-1908
9. AGE (In years and months) 58 yrs		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel owner		10b. KIND OF BUSINESS OR INDUSTRY Motel & Bar	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Green		14. MOTHER'S MAIDEN NAME ADA TRAVERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 220-32-9543	
17. INFORMANT Lena Green, Cambridge, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 176x IMMEDIATE CAUSE (a) Bullet wound chest DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 Min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shot self with pistol	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 10.20AM 8/4/67	20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Home	20f. (City or town) (County) (State) Cambridge Dor. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 8/6/67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 8/8/67	23c. NAME OF CEMETERY OR CREMATORY Bethel	23d. LOCATION (City or town) (County) (State) Cambridge Dorchester Md
24. FUNERAL DIRECTOR Wanda L. West Cambridge Md		25a. RECEIVED BY REG. STRA. DATE AUG 8 1967	25b. REG. STRA. SIGNATURE Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10952

CERTIFICATE OF DEATH

10952

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>X. SMITH</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CAMP B. OF MARYLAND HOSPITAL, INC.</u>		d. STREET ADDRESS <u>201 MACAS LANE</u>	
3. NAME OF DECEASED (Type or print) First <u>WILFRED</u> Middle <u>VINCENT</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 1, 1929</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	9. AGE (In years last birthday) yrs. <u>37</u>
11. BIRTHPLACE (County & State, or foreign country) <u>NO SHANTUNG CO., CHINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WAS GREEN</u>		14. MOTHER'S MAIDEN NAME <u>COLE CAMPBELL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>011-07-3205A</u>	
17. INFORMANT <u>ADLTY GREEN</u>		Address <u>CAMP B. OF MARYLAND HOSPITAL, INC.</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>443A</u> IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO (b) <u>hypertensive arteriosclerotic heart disease</u> DUE TO (c) <u>---</u>			INTERVAL BETWEEN ONSET AND DEATH <u>---</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1967</u> to <u>August 12, 1967</u> that (I) (we) last saw the deceased alive on <u>August 12, 1967</u> , and that death occurred at <u>---</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>J. W. Fawcett</u>		22b. DATE SIGNED <u>August 13, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. W. Fawcett, M.D.</u>		22d. ADDRESS <u>623 High Street Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>3/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL</u>	23d. LOCATION (City or Town) (County) (State) <u>CAMP B. OF MARYLAND HOSPITAL, INC.</u>
24. FUNERAL DIRECTOR <u>Frederick C. Delo</u>		25a. REC'D BY REGISTRAR <u>---</u>	
ADDRESS <u>CAMBRIDGE, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>AUG 22 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10953

CERTIFICATE OF DEATH

10953

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN 1b 1 week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) First MATTIE Middle PHILLIPS Last HANSEN		4. DATE OF DEATH Month Aug. Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1897
9. AGE (In years lost birthday) yrs 70		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John R. Phillips	
14. MOTHER'S MAIDEN NAME Ida Meekins		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-16-7075		17. INFORMANT Address Mrs. John Phillips, Fishing Creek, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma sigmoid DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 yrs		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 1964, to Aug 7 , 1964, that (I) (we) last saw the deceased alive on 8-7 , 1967, and that death occurred at 2:45 M, from causes and on the date stated above.			
22a. SIGNATURE W. N. Baumann M.D.		22b. DATE SIGNED 8-7-67	
22c. PHYSICIAN'S NAME (Type) W. N. Baumann, MD		22d. ADDRESS Franklin St., Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 9 1967	23c. NAME OF CEMETERY OR CREMATORY Star Of Sea Cemetery	23d. LOCATION (City or Town) (County) (State) Golden Hill, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR DATE AUG 11 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN life Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bobtown		d. STREET ADDRESS Bobtown	
3 NAME OF DECEASED (Type or print) PHILLIP First LEON Middle HOLLIDAY Last		4 DATE OF DEATH Month August Day 27 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 13, 1914
9. AGE (In years lost birthday) 53 yrs		IF UNDER 1 YEAR Months 27 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY Caroline Foods	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William F. Camper		14. MOTHER'S MAIDEN NAME Emma V. Holliday	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO 214-30-8920	
17. INFORMANT Delsia M. Holliday, Hurlock, Md., MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute ventricular D'latation cFibrillation sec DUE TO (b) Arteriosclerotic Hypertensive Cardio DUE TO (c) renal disease with failure INTERVAL BETWEEN ONSET AND DEATH 2yrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/15 , 19 65 , to 8/27/67 , 19 67 , that (I) (we) last saw the deceased alive on 8/26/67 , 19 67 , and that death occurred at 4 A. M. from causes and on the date stated above.			
22a. SIGNATURE Harold B. Lunner M.D.		22b. DATE SIGNED 8/29/67	
22c. PHYSICIAN'S NAME (Type) Harold B. Lunner M.D.		22d. ADDRESS Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 2, 1967	23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland
24. FUNERAL DIRECTOR J. J. Hampton and Son, Federalburg, Maryland		25a. REC'D BY REGISTRAR AUG 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10955

CERTIFICATE OF DEATH

10955

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Res. dence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e. STREET ADDRESS None	
3 NAME OF DECEASED (Type or print) First HAMILTON Middle - - Last HORSEMAN, Sr		4 DATE OF DEATH Month Aug. Day 7, Year 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1904
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 63 Days 7 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY County Roads	
11 BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Winfield Horseman		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 217-10-8790	
17. INFORMANT Mrs. Hilda Horseman, Madison, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hepatitis of spleen DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Week ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/7 , 19 67 , to 8/7 , 19 67 that (I) (we) last saw the deceased alive on 8/7 , 19 67 and that death occurred at 8/7 M, from causes and on the date stated above.			
22a. SIGNATURE J. U. Thompson, MD		22b. DATE SIGNED 8/8/67	
22c. PHYSICIAN'S NAME (Type) J. U. Thompson, MD		22d. ADDRESS Cambridge, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug 9, 1967	23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR AUG 11 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10956

CERTIFICATE OF DEATH

10956

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS RFD No. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle LESLIE Last HUBBARD				4. DATE OF DEATH Month Aug. Day 15, Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1904		9. AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months 15 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Gen. Building		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Raymond Hubbard				14. MOTHER'S MAIDEN NAME Foly Marshall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-2741		17. INFORMANT Mrs. J. Leslie Hubbard, RFD 3, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma right lung with metastases to mediastinum & cervical glands DUE TO (b) glands DUE TO (c) glands Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/11/67 , 19 67 , to 8/15/67 , 19 67 , that (I) (we) last saw the deceased alive on 8/15/67 , 19 67 , and that death occurred at 8/15/67 , from causes and on the date stated above							
22a. SIGNATURE Lawrence Maryanov		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 8/17/67			
22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov		22d. ADDRESS 610 Race St Cambridge, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 19 1967		23c. NAME OF CEMETERY OR CREMATORY Spedden-Seward Cemetery		23d. LOCATION (City or Town) (County) (State) RFD 3, Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR AUG 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10957

1 PLACE OF DEATH a COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Caroline	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY IN 1b 1 Hour	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cambridge Maryland Hospital		d STREET ADDRESS Preston (Rural)	
3. NAME OF DECEASED (Type or print) First WILLIE Middle HUDSON Last JR.		4 DATE OF DEATH Month August Day 23 Year 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 5, 1940
9 AGE (In years lost birthday) 27 yrs		10 IF UNDER 1 YEAR Months 27 Days 27 Hours 27 Min 27	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b KIND OF BUSINESS OR INDUSTRY Factory	
11 BIRTHPLACE (State or foreign country) Georgia		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Hudson		14 MOTHER'S MAIDEN NAME Alice Morton	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 255-60-5783	
17 INFORMANT Willie Hudson		Address Preston, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries, severe DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Driver of car in two car collision.	
20c TIME OF INJURY Month, Day, Year Hour a.m. 1 AM p.m. 8/23/67	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f (City or town) (County) (State) Hurlock, Dor. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 8/25/67	
EXAMINER'S NAME (Type) John Mace Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Aug. 26, 1967	23c NAME OF CEMETERY OR CREMATORY Johns Cemetery	23d LOCATION (City or Town) (County) (State) Preston Caroline Maryland
24. FUNERAL DIRECTOR Frampton Funeral Home-Federalburg, Md.		25a REC'D BY REGISTRAR AUG 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10958

10958

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 1 yr. 5 mo 18 da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS R.F.D.	
3. NAME OF DECEASED (Type or print) First ADDIE Middle Last JONES		4. DATE OF DEATH Month 8 Day 5 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1883
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State or foreign country) DOR. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME BENJAMIN JONES		14. MOTHER'S MAIDEN NAME MARY A. COULBOURNE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO 218-20-5335	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 4 DAYS 1 1/2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the (this hospital) attended the deceased from 2-18-66 , 19 to 8-5- , 1967, that (I) we last saw the deceased alive on 8-5- , 1967, and that death occurred at 1130 AM , from causes and on the date stated above.			
22a. SIGNATURE Edward Lewis		22b. DATE SIGNED 8-5-67	
22c. PHYSICIAN'S NAME (Type) EDWARD LEWIS, JR., MD		22d. ADDRESS ESSH-CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF Aug. 8, 1967	
23c. NAME OF CEMETERY OR CREMATORY Cokesbury Cemetery		23d. LOCATION (City or town) (County) (State) Near Federalsburg Md.	
24. FUNERAL DIRECTOR Edmonton Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE AUG 18 1967	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-101. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10959

10959

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY IN 1b 20 years	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 308 Talbot Ave.,		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Benjamin Kidan		4. DATE OF DEATH August 16, 1967	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 18, 1908
9 AGE (In years last birthday) 58		10 IF UNDER 1 YEAR F UNDER 24 HRS Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Sewing Factory		10b KIND OF BUSINESS OR INDUSTRY New York City	
11 BIRTHPLACE (State or foreign country) U.S.		12 CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Moses Kidan		14. MOTHER'S MAIDEN NAME Flora Rosenberg	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W. 2		16 SOCIAL SECURITY NO 062-01-5698	
17 INFORMANT Mrs. Marion J. Kidan, Cambridge, Md.		18 ADDRESS 308 Talbot Ave.,	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carbon monoxide poison DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Suicide by carbon monoxide in automobile	
20c TIME OF INJURY Month, Day, Year 8 AM 8-16 1967	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e PLACE OF INJURY (Home farm factory street office bldg, etc.) In auto-home	20f (City or town) (County) (State) Cambridge Dor. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John H. Ace Jr.		22. DATE SIGNED 8/17/67	
EXAMINER'S NAME (Type) John H. Ace Jr.		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Aug. 18, 1967	23c NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Md.	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR Reemeth R. Shoups	25a REC'D BY REGISTRAR AUG 23 1967	25b REGISTRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

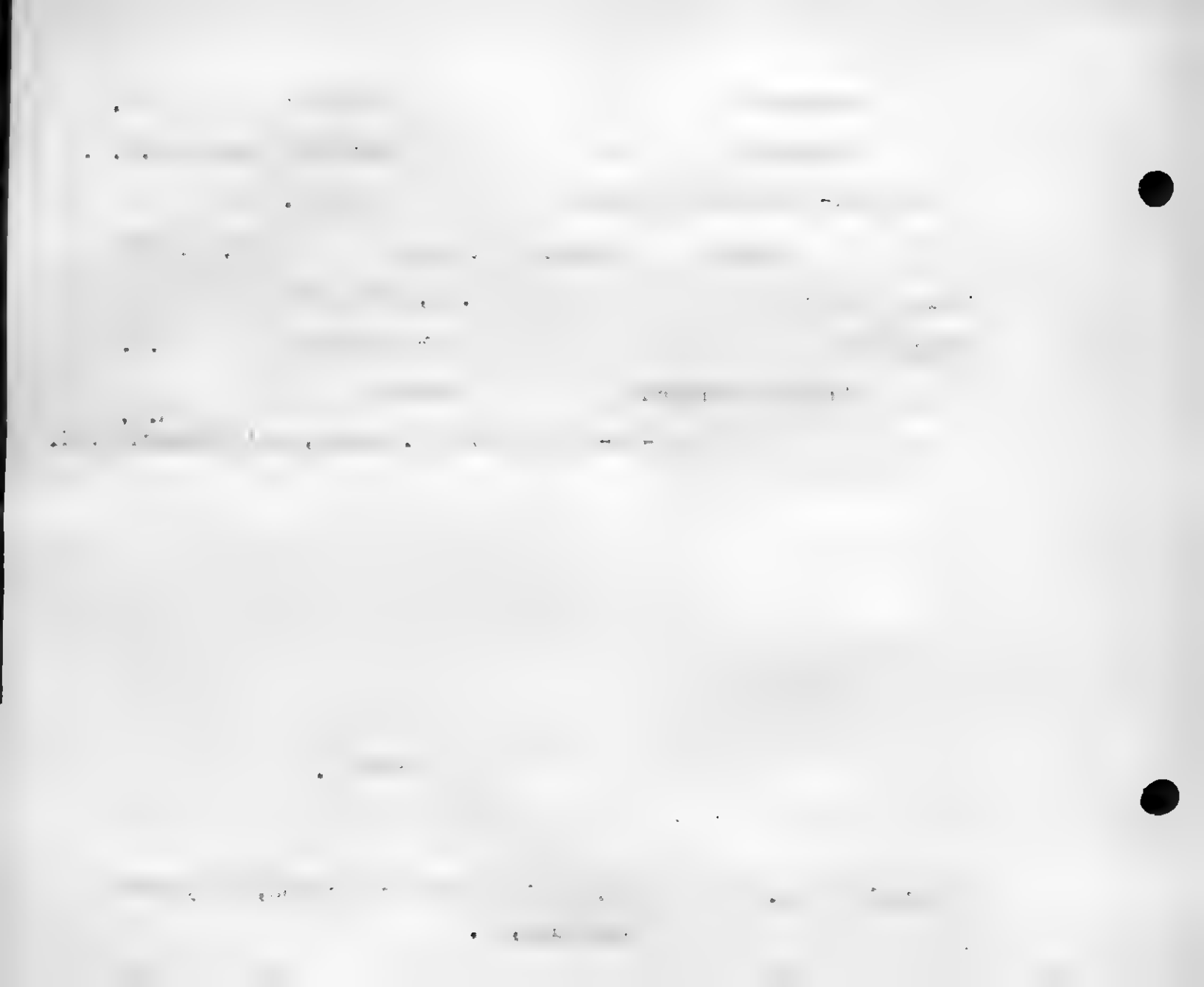
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10960

10960

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN ID 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dor. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East New Market, Md. R.D. d. STREET ADDRESS Rural Rt. 16 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Helen Middle Virginia Last Knaack		4. DATE OF DEATH Month Aug. Day 27 Year 1967		5. SEX Female			
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1902			
9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Talbot County			
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME William Collisen			
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-40-3443			
17. INFORMANT Jehnie E. Knaack, East New Market, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Disease 153.3 DUE TO (b) _____ Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 15 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>5-20</u>, 19<u>66</u>, to <u>8-27</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>8-27</u>, 19<u>67</u>, and that death occurred <u>8:30 A.</u> from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 8-28-67			
22c. PHYSICIAN'S NAME (Type) J. R. Thomas				22d. ADDRESS Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery			
23d. LOCATION (City, town or county) Easton, Maryland		(State) _____		25a. REC'D BY REGISTRAR SEP 1 1967			
25b. REGISTRAR'S SIGNATURE 							



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

10961
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
10961

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) East New Market				c. LENGTH OF STAY IN ID 1 Month			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Steven's Nursing Home				e. STREET ADDRESS 721 Bailey Road			
3. NAME OF DECEASED (Type or print) First Sallie Middle Brown Last Larimore				4. DATE OF DEATH Month Aug Day 26 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12, 1883	
9. AGE (In years last birthday) 83 yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife			
13. FATHER'S NAME John Brown				14. MOTHER'S MAIDEN NAME Sallie Larimore			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Address Le Compte Funeral Service, Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Ventricular Fibrillation with 4200 DUE TO Left Ventricular Distention, Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Heart disease with auricular Fibrillation 4 yrs (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH minutes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/14 , 19 67 to 8/26/67 , 19 67 , that (I) (we) last saw the deceased alive on 8/24 , 19 67 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Harold B. Plummer				22b. DATE SIGNED 8/30/67			
22c. PHYSICIAN'S NAME (Type) Harold B. Plummer M.D.				22d. ADDRESS Preston Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug 29, 1967		23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) Cambridge, Md.	
24. FUNERAL DIRECTOR Le Compte Funeral Service, 308 High St, Cambridge, Md.				25a. REC'D BY REGISTRAR SEP 5 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10962

CERTIFICATE OF DEATH

10562

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY WICOMICO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN TB 6 WEEKS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS 628 HILL ST.	
3. NAME OF DECEASED (Type or print) First BERTHA Middle BURNETT Last MILBOURNE		4. DATE OF DEATH Month AUGUST Day 31 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE INDIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/19/90
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR Months Days Hours M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Burnett	
14. MOTHER'S MAIDEN NAME ELEANOR BURNETT Robinson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. 218-24-4319A		17. INFORMANT HOSPITAL RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar Pneumonia 470X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile cachexia DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/16 , 19 67 , to 8/31 , 19 67 that (I) (we) last saw the deceased alive on 8/31 , 19 67 , and that death occurred at 8:10 AM , from causes and on the date stated above			
22a. SIGNATURE Carlos F Barroso		22b. DATE SIGNED 8/31/67	
22c. PHYSICIAN'S NAME (Type) CARLOS F BARROSO		22d. ADDRESS E.S.S. HOSPITAL, CAMBRIDGE, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-4-67	23c. NAME OF CEMETERY OR CREMATORY Green Acres Park	23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.
24. FUNERAL DIRECTOR Bonetta B. Jolley		25a. REC'D BY REGISTRAR James R. Jolley	
25b. REGISTRAR'S SIGNATURE James R. Jolley		DATE SEP 6 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10963

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 24 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Maryland Hospital		d. STREET ADDRESS 906 Camelia Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Amanda Shackelford North		4. DATE OF DEATH Month Day Year Aug. 15, 1967 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1904	9. AGE (in years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Fredericks, Va.	
13. FATHER'S NAME Nathaniel Shackelford		14. MOTHER'S MAIDEN NAME Julia Brooks		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-12-4961		17. INFORMANT 906 Camelia Street Paul A. Trigger, Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					INTERVAL BETWEEN ONSET AND DEATH 6 1/2 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 1-31, 1967 to 8-15, 1967 , that (I) (we) last saw the deceased alive on 8-15, 1967 , and that death occurred at 4:30 PM from the causes and on the date stated above.					
22a. SIGNATURE [Signature]		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-21-67	
22c. PHYSICIAN'S NAME (Type) [Name]		22d. ADDRESS [Address]			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery	23d. LOCATION (City, town or county) (State) Cambridge, Md.		
24. FUNERAL DIRECTOR [Signature]		25a. REC'D BY REGISTRAR [Signature]		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10964

CERTIFICATE OF DEATH

10964

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 805 Radiance Dreive		e. STREET ADDRESS None	
3. NAME OF DECEASED (Type or print) BERTHA First MEREDITH Middle ROBINSON Last		4. DATE OF DEATH Month Aug. Day 30 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1882
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 1 Days 12 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Meredith		14. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO unk	
17. INFORMANT Mrs Hiram Johnson, Cambridge, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia & Heart Failure 44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hypertension - arteriosclerosis CV RD DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 1 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug 12, 1967 to Aug 30, 1967 that (I) (we) lost saw the deceased alive on Aug 30, 1967 , and that death occurred at 11 A-M , from causes and on the date stated above.			
22a. SIGNATURE J. U. Thompson		22b. DATE SIGNED 8/31/67	
22c. PHYSICIAN'S NAME (Type) J. U. Thompson, MD		22d. ADDRESS Cambridge, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 2 1967	23c. NAME OF CEMETERY OR CREMATORY Toddville Meth Churchyard	23d. LOCATION (City or Town) (County) (State) Toddville, Maryland
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR DATE SEP 5 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

10965

CERTIFICATE OF DEATH

10965

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~fill in~~ ^{attach} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CAMBRIDGE		c. LENGTH OF STAY IN 1b 12 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) EASTERN SHORE STATE HOSPITAL		d. STREET ADDRESS 702 MARKET ST.	
3. NAME OF DECEASED (Type or print) First MIN Middle Pearson Last SCHOOLFIELD		4. DATE OF DEATH Month AUGUST Day 24 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/92
9. AGE (n years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOMAS PEARSON		14. MOTHER'S MAIDEN NAME Nancy Cecil	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1536 IMMEDIATE CAUSE (a) Diffuse peritonitis DUE TO (b) Inflammation of colon DUE TO (c) Carcinoma of asc. colon + adhesions			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from JULY 22 1955, to AUG. 24 1967, that (I) (we) last saw the deceased alive on AUG. 24 1967, and that death occurred at M , from causes and on the date stated above			
22a. SIGNATURE P. W. Riecker		22b. DATE SIGNED 8/24/67	
22c. PHYSICIAN'S NAME (Type) P. W. Riecker		22d. ADDRESS E.S.S.H., CAMBRIDGE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-26-1967	23c. NAME OF CEMETERY Presbyterian	23d. LOCATION (City or Town) (County) (State) Pocomoke City Wor. Md.
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR AUG 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Galestown		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Galestown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First EVELYN		Middle HASTINGS		Last SHORT		4. DATE OF DEATH Month August		Day 4	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 4, 1902		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Galestown, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Howard L. Hastings						14. MOTHER'S MAIDEN NAME Hattie Wheatley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hastings		Address Miss Louise Short, Galestown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Primary Tuberculosis DUE TO (b) Diphtheria DUE TO (c) Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 254 mos. 84 mos. 44 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 1942 to 1951 , that (I) (we) last saw the deceased alive on 1951 , and that death occurred at 9:55 M. from the causes and on the date stated above.											
22a. SIGNATURE H. S. Kuhlman											
22b. DATE SIGNED Aug 5/67											
22c. PHYSICIAN'S NAME (Type) H. S. Kuhlman											
22d. ADDRESS Sharptown Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Galestown Cemetery		23d. LOCATION (City, town or county)		(State)			
24. FUNERAL DIRECTOR J. J. Frantz		ADDRESS Frantz and Son		25a. REC'D BY REGISTRAR AUG 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

2

1

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13

13

13

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10967

10867

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Church Creek</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland</u>		d. STREET ADDRESS <u>None</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thorman</u> Middle <u>M.</u> Last <u>Shorter</u>		4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08-20-88</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dirt Machine</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon Shorter</u>		14. MOTHER'S MAIDEN NAME <u>A. Ellen Shorter Lawson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>Patent's chart</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable massive myocardial infarction</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized atherosclerosis</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-5-67</u> , 19 <u> </u> to <u>8-20-</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>8-20-67</u> 19 <u> </u> , and that death occurred at <u>2:15</u> A.M., from causes and on the date stated above			
22a. SIGNATURE <u>Edward Lewis, Jr.</u>		22b. DATE SIGNED <u>8-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR.</u>		22d. ADDRESS <u>ESSH CAMBRIDGE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Aug 23 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>East New Market, Maryland</u>
24. FUNERAL DIRECTOR <u>LECOMPTRE FUNERAL SER., CAMBRIDGE, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 22 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>



Page

1000 1000 1000



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10968

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN ID 1 hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 307		d. STREET ADDRESS 600 block W. Long St.	
3 NAME OF DECEASED (Type or print) Curtis		4 DATE OF DEATH Month August Day 23 Year 19 67	
5 SEX Male	6 COLOR OR RACE Black	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH ?
9 AGE (In years last birthday) 22 yrs	10 IF UNDER 1 YEAR Months 22 Days 22 Hours 22 Min 22		11 IF UNDER 24 HRS Months 22 Days 22 Hours 22 Min 22
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Migrant laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm labor	
11 BIRTHPLACE (State or foreign country) Florida ?		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT Cambridge Hospital records		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY			
IMMEDIATE CAUSE (a) Intracranial injuries			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			
(b) Instant			
DUE TO			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Two car collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1AM p.m. 8/23/67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Hurlock Dor. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Not a natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Ace Jr.		22. DATE SIGNED 8/23/67	
EXAMINER'S NAME (Type) John Ace Jr.		23a. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county) Baltimore, Md.	
23b. BURIAL (CREMATION REMOVAL, Specify) 8.28.67	23c. DATE THEREOF 8.28.67	23d. NAME OF CEMETERY OR CREMATORY U. of Md. Med. School	23e. LOCATION (City or Town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR AUG 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



10963

CERTIFICATE OF DEATH

10969

1 PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		MARYLAND c. LENGTH OF STAY IN 1b 7Hrs. 12 Mins		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital Inc.			d. STREET ADDRESS 122 Vue de Leau St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Slacum			4. DATE OF DEATH Month Day Year August 6 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 6, 1967		9. AGE (In years last birthday) yrs 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Dorchester-Maryland	
13. FATHER'S NAME Lyn Birtcell Slacum			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT Cambridge, Md. Mrs Glenda Slacum 122 Vue de Leau St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 776X DUE TO Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8-6 , 19 67 , to 8-6 , 19 67 , that (I) (we) last saw the deceased alive on 8-6 , 19 67 , and that death occurred at 8:45 PM , from causes and on the date stated above.					
22a. SIGNATURE Fernandez			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-6-67
22c. PHYSICIAN'S NAME (Type) EFRAIN C. FERNANDEZ			22d. ADDRESS 138 Race St. Cambridge Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7 AUG '67	23c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEM. PARK		23d. LOCATION (City or Town) (County) (State) CAMBRIDGE DOR. MD.	
24. FUNERAL DIRECTOR Kenneth R Thomas Jr.			ADDRESS CAMBRIDGE MD.		25a. REC'D BY REGISTRAR AUG 9 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10970

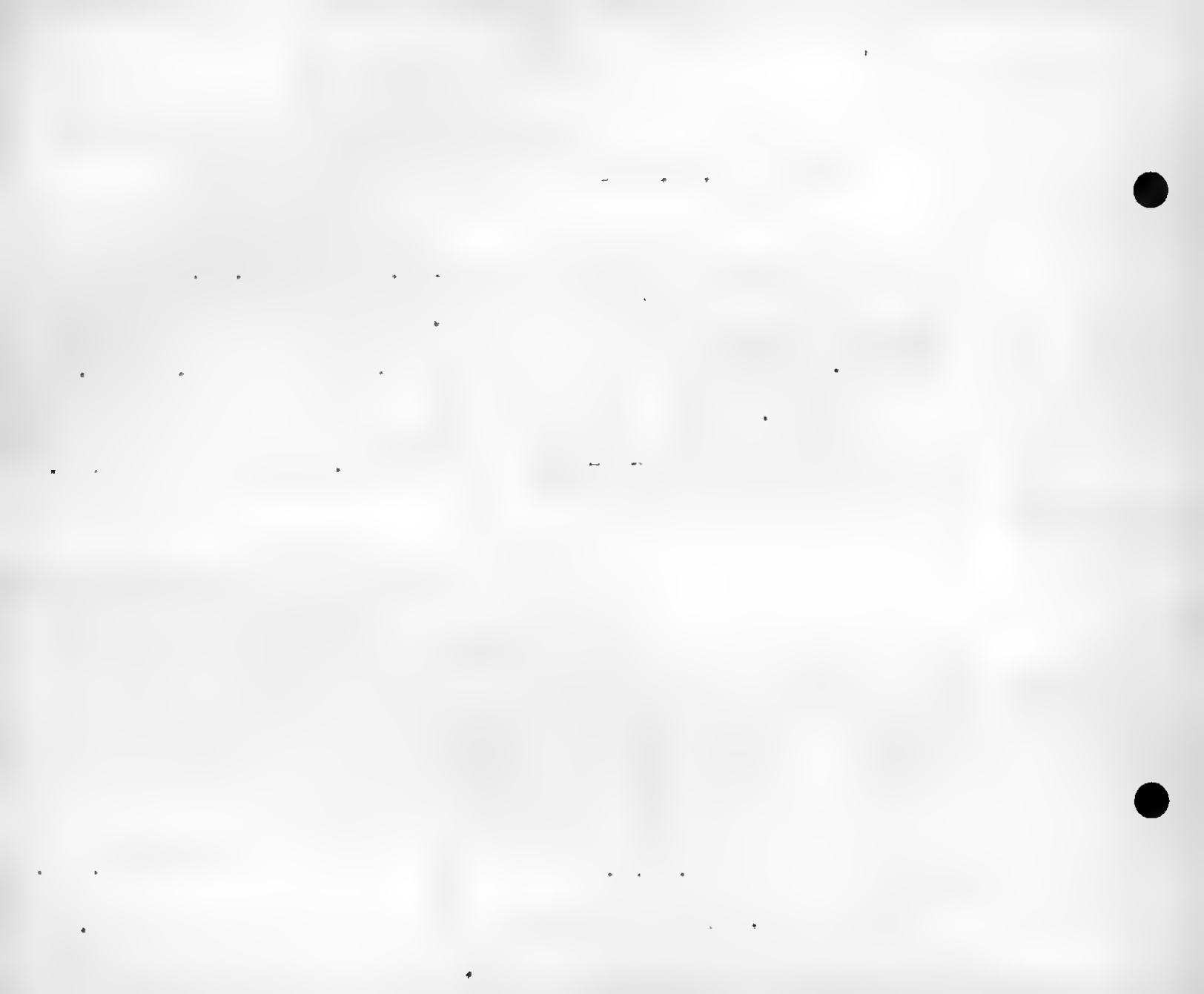
10970

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews, Dor. Co. entire life	c. LENGTH OF STAY IN 1b entire life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural		d. STREET ADDRESS 1104 Race Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) James Wilby Slacum, Sr.		4. DATE OF DEATH Month Aug. Day 25 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 5, 1900
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Freight Co. Manager		10b KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) 66 yrs
11 BIRTHPLACE (State or foreign country) Andrews, Dorchester Co.		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME James D. Slacum		14 MOTHER'S MAIDEN NAME Fannie Hooper	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 214-07-7718	
17 INFORMANT Mrs. Nettie H. Slacum, Cambridge, Md.		Address 1104 Race Street	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 8/27/67	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cambridge, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Aug. 27, 1967	23c NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park, Cambridge, Md.	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR James R. Howell		25a REC'D BY REGISTRAR SEP 1 1967	25b REGISTRAR'S SIGNATURE Charles Judge



10971

CERTIFICATE OF DEATH

10971

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c LENGTH OF STAY IN 1b 2 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ETTA T. SULLENDER		4 DATE OF DEATH Month Day Year Aug. 17 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 14, 1877
9. AGE (in years last birthday) yrs. 90		IF UNDER 1 YEAR Months Days Hours Min 19 67	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME William H. Todd		14 MOTHER'S MAIDEN NAME Melvinia Bramble	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-14-4212	
17 INFORMANT Mrs McClain Robinson, Crocheron, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO (b) Hypertensive Heart Disease DUE TO (c) 20 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/14 , 1967, to 8/17 , 1967, that (I) (we) lost the deceased alive on 8/17 , 1967, and that death occurred at 6 PM from causes and on the date stated above.			
22a SIGNATURE Lawrence Maryanov		22b DATE SIGNED 8/18/67	
22c PHYSICIAN'S NAME (Type) Lawrence Maryanov MD		22d ADDRESS 610 Race St. Cambridge, Md	
23a B. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF Aug 20, 1967	
23c NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a REC'D BY REGISTRAR AUG 22 1967	
25b REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10972

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10972

1 PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Florida b. COUNTY ?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		c. LENGTH OF STAY IN 1b Cant say	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Buck Andrews Labor Camp		e. STREET ADDRESS ?	
3 NAME OF DECEASED (Type or print) Herman Taylor (alias Hank Martin)		4 DATE OF DEATH Month 8 Day 7 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Unknown
9 AGE (in years last birthday) About 40		10 IF UNDER 1 YEAR Months ? Days ? Hours ? Min. ?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Migrant Laborer		10b. KIND OF BUSINESS OR INDUSTRY Migrant Labor	
11 BIRTHPLACE (State or foreign country) Unknown		12 CITIZEN OF WHAT COUNTRY? Unknown	
13 FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subdural Hemorrhage DUE TO (b) ? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) ?			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B) Beaten up by another migrant.	
20c. TIME OF INJURY Month Day Year Hour ? am 8/7/67 pm	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.) Labor camp	20f. (City or town) (County) (State) Hurlock Dor. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22. DATE SIGNED 8/7/67	
EXAMINER'S NAME (Type) John Mace Jr.		Address (Street, city, town, or county)	
23a. BURIAL (CREMATION REMOVAL (Specify))	23b. DATE THEREOF 8-21-67	23c. NAME OF CEMETERY OR CREMATORY V. of Ind. Med. School Baltimore, Md.	23d. LOCATION (City or town) (County) (State) Baltimore, Md.
24 FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE AUG 23 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

10973

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10973

1 PLACE OF DEATH a COUNTY Dorchester MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Dorchester	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cambridge R.F.D.		c LENGTH OF STAY IN life All life	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ---		d STREET ADDRESS Cambridge, Md. R.F.D. (Bucktown)	
3 NAME OF DECEASED (Type or print) Charlotte Thompson First THOMAS Middle --- Last ---		4 DATE OF DEATH Month August Day 1 Year 1967	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-1-1872 yrs 95 mos 4 days 20
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY ---	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME MARTIN LAKE		14 MOTHER'S MAIDEN NAME NANDY CAMPER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO ---	
17 INFORMANT DaRue Pinder, Cambridge, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) --- DUE TO (c) ---			INTERVAL BETWEEN ONSET AND DEATH Instant
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. --- p.m. --- 19 ---	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f (City or town) (County) (State) ---
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		22 DATE SIGNED 8/4/67	
EXAMINER'S NAME (Type) John Mace Jr.		Address (Street, city, town, or county) ---	
23a BIRTH (Place, Date, Time) Bucktown, Dorchester, Md.	23b DATE OF BIRTH 8/6/67	23c NAME OF CEMETERY OR CREMATORY Bucktown	23d LOCAL (City or Town) (County) (State) Bucktown, Dorchester, Md.
24 FUNERAL DIRECTOR Hilda L. West	24b ADDRESS Cambridge	25a REC'D BY REGISTRAR ---	25b REGISTRAR'S SIGNATURE Charles Judge
DATE AUG 8 1967			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 2 3 4 5

6 7 8

9 10

11 12 13 14

15 16 17

18 19 20 21 22

23

24 25 26 27 28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
10874
10874

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER COUNTY</u> <u>Cambridge Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Hospital</u>				d. STREET ADDRESS <u>Life</u>			
3. NAME OF DECEASED (Type or print) First <u>Roger</u> Middle <u>Williams</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-02</u>	
9. AGE (in years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>10</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farm work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>John Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Camille Thomas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-07-8763</u>		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular hemorrhage - Uremia</u>							
442X DUE TO (b) <u>arteriolosclerotic cardiovascular</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>renal disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Sick R on Sol. Taking to Camb Hosp</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street/office bldg., etc.) <u>Farm</u>	
				20f. (City or town) (County) (State) <u>Town Port Md</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>August 10 1967</u> to <u>August 24 1967</u> that (I) (we) last saw the deceased alive on <u>August 24 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>August 24, '67</u>			
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett, M.D.</u>				22d. ADDRESS <u>623 High Street, Camb., Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		23d. LOCATION (City, town or county) (State) <u>Cambridge Md</u>	
24. FUNERAL DIRECTOR <u>Hilda West</u>				ADDRESS <u>Salisbury Md</u>		25a. REC'D BY REGISTRAR <u>Aug 29 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10975

20575

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Thomas</u> Last <u>Tobat Sn</u>				4. DATE OF DEATH Month <u>8</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/12/1998</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>Michael Tobat</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>			16. SOCIAL SECURITY NO. <u> </u>		14. MOTHER'S MAIDEN NAME <u>Josephine Koswaski</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA FROM SIGMOID</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that (1) (this hospital) attended the deceased from <u>3-31</u> , 19 <u>67</u> , to <u>8-7</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>8-7</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>James F. McCarter</u>			22b. DATE SIGNED <u>8-8-67</u>		22c. PHYSICIAN'S NAME (Type) <u>James F. McCarter, M.D.</u>		
22d. ADDRESS <u>704 LOCUST ST. CAMA, MD. 21613</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Our Lady of Good Counsel</u>	23d. LOCATION (City, town or county) (State) <u>Secretary MD.</u>				
24. FUNERAL DIRECTOR <u>Keith S. Hilborn, East New Market</u>			25a. REC'D BY REGISTRAR DATE <u>AUG 10 1967</u>				
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10976

10976

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b HRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Cambridge-Md. Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pittsville d. STREET ADDRESS Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Raymond White				4. DATE OF DEATH Month Day Year August 4 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/20/1873	
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John William White				14. MOTHER'S MAIDEN NAME Laura Ellen Freeny			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 217-48-2365		17. INFORMANT Address Mrs. Laura Wells Pittsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) medullary paralysis - long failure DUE TO (b) arterio-sclerosis CVD DUE TO (c) arterio-sclerosis gen Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia							INTERVAL BETWEEN ONSET AND DEATH 24 hrs ? L
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 3, 1967 , to Aug 4, 1967 that (I) (we) last saw the deceased alive on Aug 3, 1967 , and that death occurred at 7:20 M. from the causes and on the date stated above.							
22a. SIGNATURE A. Thompson				22b. DATE SIGNED 8/5/67			
22c. PHYSICIAN'S NAME (Type) A. Thompson				22d. ADDRESS Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/8/67		23c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		23d. LOCATION (City, town or county) (State) Pittsville Md.	
24. FUNERAL DIRECTOR Hill Funeral Home				ADDRESS Salisbury Md.		25a. REC'D BY REGISTRAR DATE AUG 3 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10977

CERTIFICATE OF DEATH

10977

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				d. STREET ADDRESS RFD No. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGIA Middle MARSHALL Last WINGATE				4. DATE OF DEATH Month Aug. Day 30 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14, 1878		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eljiah Marshall				14. MOTHER'S MAIDEN NAME Sallie Thomas			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. unk		17. INFORMANT Address Mrs. Evelyn Thomas, RFD 3, Cambridge, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HT. DISEASE 4200 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 wks							
PART II. OTHER SIGNIFICANT CONITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8/13 , 1967, to 8/30 , 1967, that (I) (we) last saw the deceased alive on 8/30 1967, and that death occurred at 2:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Alfred R. Maryanov				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/31/67	
22c. PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV				22d. ADDRESS 610 Race St. Cambridge MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 1 1967		23c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		23d. LOCATION (City or Town) (County) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland				25a. REC'D BY REGISTRAR DATE SEP 5 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

MEDICAL CERTIFICATION

1007

Director
General
Special Agent
Mr. J. Edgar Hoover
Washington, D. C.
Dear Sir:
Enclosed for you are two copies of a letterhead memorandum
dated and captioned as above.
Very truly yours,
J. Edgar Hoover
Director

Enclosure
J. Edgar Hoover
Director
U. S. Department of Justice
Washington, D. C.

1007
J. Edgar Hoover
Director
U. S. Department of Justice
Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item d 8/14/67 Jdc

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Vienna</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>		d. STREET ADDRESS <u>P.O.</u>	
3. NAME OF DECEASED (Type or print) <u>Alma</u> First Middle Last		4. DATE OF DEATH <u>8</u> Month <u>4</u> Day <u>1967</u> Year	
5. SEX <u>7</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1912</u> 9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Vienna</u>	
13. FATHER'S NAME <u>ISSAC JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pinkett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-03-5645</u>	
17. INFORMANT <u>James R. Young</u> Address <u>Vienna, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u> DUE TO (b) <u>Carcinoma of right ovary</u> DUE TO (c) <u>1 yrc?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> to <u>Aug 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 4</u> , 19 <u>67</u> , and that death occurred at <u>10 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE <u>Lewis M. Burdette</u> M.D.		22b. DATE SIGNED <u>Aug 8, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lewis M. Burdette</u>		22d. ADDRESS <u>4 Aurora St. Cambridge, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Salem</u>	23d. LOCATION (City or Town) (County) (State) <u>Salem Dorc. Md.</u>
24. FUNERAL DIRECTOR <u>Harriet B. Jolley - Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles J. Jolley</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jolley</u>	
DATE <u>AUG 14 1967</u>			

10978

10978

